NOURISH NATURAL HEALTH CLINIC

Shannon R. May, N.D., L.Ac
Naturopathic Doctor and Acupuncturist

Pediatric Intake Packet (birth to 5 years)

Welcome to Nourish Natural Health Clinic, LLC. In order to provide your child with the best possible care, we ask you to complete this form in its entirety. Thank you!

Patient Information

Name: _____ Date: _____
Parent's names: _____
Address: _____
Telephone: (home): _____ (Parent's work): _____(cell): _____
Preferred number for messages and appointment reminders?_____
Can Nourish Natural Health Clinic identify themselves when leaving a message?_____
Is it okay to leave a message with detailed information?_____
Parent's e-mail: _____
Age: _____ Date of Birth: _____ Gender: F M Ethnic heritage: _____
How did you hear about this clinic? _____
May we thank them for the referral? yes ____ no ____
Has any other family member been seen at my practice? _____
Name of doctor's office/hospital/clinic where your child's health records are kept: _____
_____
Reason for today's visit or chief complaint:
_____
_____

Current Health History
Does your child have a Primary Care Provider? Y / N
If yes, please give their name, location, and phone number: _____
_____

Medications

Now	Past		Now	Past	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamines
____	____	Antibiotics	____	____	Other: _____
____	____	Ibuprofen			

Is your child currently taking any vitamins or supplements?
Please list:
_____
_____
_____

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Allergies
Is your child hypersensitive or allergic to….
Any drugs?

_____

Any foods?

_____

Environmental allergens/chemicals?

_____

Family History (please circle)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Arthritis	Birth Defects	Tuberculosis	Mental Illness
Asthma	Allergies	Osteoporosis	Eczema

Any other relevant family history?

_____

Immunizations

Polio	Y N	Influenza	Y N
DPT	Y N	Hib	Y N
Tetanus	Y N	Hep B	Y N
Diptheria	Y N	MMR	Y N
Pertussis	Y N	Chicken Pox	Y N

Adverse reactions? Y N If yes, what? _____
Other:_____

Medical History

Rheumatic fever	Y N	Mumps	Y N
Chicken Pox	Y N	Measles	Y N
Scarlet fever	Y N	Rubella	Y N
Frequent colds	Y N	Pneumonia	Y N
Ear infections	Y N	Approx. no. of times:_____	
Strep throat	Y N	Approx. no. of times:_____	
Tonsillitis	Y N	Approx. no. of times:_____	

Other: _____
Has your child had any of the following tests? Indicate when and where and results.
Electroencephalogram (EEG):

_____

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Psychological evaluation:

_____

Hearing tests:

_____

Speech/language tests:

_____

Injuries/surgeries/hospitalizations (please list):

_____

_____

Exposures:
Has your child been exposed to second hand smoke? Y / N For how long?_____
Is your child in daycare? Y / N

Diet
Does your child follow a specific diet? Please explain: _____

Typical Food Intake:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Prenatal History
Previous pregnancies by natural mother, miscarriages, or complications?

_____

Mother's age at child's birth? _____
Mother's health during pregnancy:

_____ Bleeding	_____ Physical or emotional trauma	_____ Nausea
_____ Illnesses	_____ Medications	_____ Hypertension
_____ Thyroid problems	_____ Cigarettes, alcohol, drug consumption	_____ Diabetes

Birth History
Pregnancy term: _____ Full _____ Premature _____ Late
Child's weight at birth: _____
Labor/delivery complications?_____
Did your child have any of the following problems shortly after birth?

_____ Birth defects	_____ Birth injuries	_____ Blue baby
_____ Cerebral palsy	_____ Seizures	_____ Jaundice
_____ Colic	_____Fever	_____ Rashes

Other:_____

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Child's sleep patterns (1st year):_____
Food intolerances (if any):_____
Feeding: Breast fed? Y / N How long? _____ Formula? Y / N Type (milk/soy): _____
Age began solids: _____ Which foods?_____
Age began (if applicable): Sitting _____ Crawling _____ Walking _____ Talking _____

Symptoms
(Mark Y if current, P for past symptoms, leave blank if never)

_____ Hives
_____ Allergies
_____ Eczema
_____ Chronic rash
_____ Acne
_____ Headaches
_____ Dizzy spells
_____ Hair loss
_____ Hearing loss
_____ Vision problems
_____ Nose bleeds
_____ Frequent colds
_____ Bleeding gums
_____ Canker sores
_____ Dental caries
_____ Sore throats

_____ Wheezing
_____ Asthma
_____ Cough
_____ Breath/body odor
_____ Sensitive to light
_____ Nervous
_____ Cries easily
_____ Sleep problems
_____ Nightmares
_____ Unusual fears
_____ Heart murmur
_____ No appetite
_____ Jaundice
_____Stomach aches
_____ Motion/car sickness
_____ Gas

_____ Constipation
_____ Diarrhea
_____ Vomiting spells
_____ Frequent urination
_____ Bloody urine
_____ Burning of urine
_____ Bleeding tendency
_____ Easy bruising
_____ Anemia
_____High fevers
_____ Night sweats
_____ Excessive fatigue
_____ Flat feet
_____ Joint pains

Is there anything else you would like for me to know?

Thank you. I look forward to helping your child in every way I can. If you have any questions please ask!
~ Dr. Shannon May

Informed Consent and Request for Naturopathic Medical Care, Chinese

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Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to un¬dergo care with Dr. Shannon R. May, ND, L.Ac, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____ , hereby request and consent to examination and treatment with Naturopathic Medicine and Chinese Medicine by Dr. Shannon R. May, ND, L.Ac, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Shannon R. May, ND, L.Ac, and/ or with the allied health care provider providing backup:

1.) my suspected diagnosis(es) or condition(s)
2.) the nature, purpose, goals and potential benefits of the proposed care
3.) the inherent risks, complications, potential hazards or side effects of treatment or procedure
4.) the probability or likelihood of success
5.) reasonable available alternatives to the proposed treatment procedure
6.) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and therapeutic adjustment (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic adjustment of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

The scope of practice of acupuncture is outlined below. I understand that Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)

- Herbs (use of patented herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.
Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.
Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.
Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Shannon R. May, ND, L.Ac,, of these conditions. Please Initial:

____I understand that Dr. Shannon R. May, ND, L.Ac, is not licensed to prescribe any controlled substances.

____I understand that Dr. Shannon R. May, ND, L.Ac will provide the appropriate referrals to manage any prescription med needs.

____I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substanc¬es; however these have been used widely in Europe, China and the USA for years.

____I understand that Dr. Shannon R. May, ND, L.Ac is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Shannon R. May, ND, L.Ac, and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. May explain thera¬pies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condi¬tion and any future conditions for which I seek treatment
Printed Name of Patient_____ Signature of Patient_____
Printed Name of Guardian_____ Signature of Guardian_____
Date Signed_____

Notice of Privacy Practices

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Nourish Natural Health Clinic, LLC

Nourish Natural Health Clinic, LLC refers to Dr. Shannon R. May, her student preceptors and her contracted employees.

This notice describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully. We are legally obligated to provide this information to you. It is subject to change and updated versions are always available from Dr. May.

Nourish Natural Health Clinic, LLC is the private medical practice of Dr. Shannon R. May. The majority of the time Dr. May is the only person with access to your medical information; however, there are a few instances in which she may share pertinent information about you for the purposes of treatment, payment or health care operations. She may disclose your health information to other health professionals, their staff or students who may consult on your treatment or the coordination of your health care.

Nourish Natural Health Clinic, LLC also uses and discloses your health information for billing and payment collection from you, an insurance company, or someone else for health care services you receive from us. We may also tell your insurance company about your proposed treatment to determine whether your plan will pay for the treatment.

We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance, and business functions of Nourish Natural Health Clinic, LLC. Data about effectiveness of treatments and what services we should offer may be gathered from patient's health information. We may also use and disclose your health information to contact you regarding treatment options, products or services and for appointment reminders.

Other potential instances in which your health information could be disclosed without your explicit permission include legal obligations at the federal, state or local level to disclose to specified parties for purposes including subpoenas/ court orders, public health risks, governmental agency oversight of health care, threats to health or safety, disaster relief, national security, for identification of deceased persons, or for the purpose of organ or tissue transplantation. Military command or government authority may acquire information about veterans or members of the military. Correctional institutions may acquire information about inmates for the purpose of providing health care and safety. Information about employees can be disclosed to employers regarding worker's compensation type programs.

With some rare exceptions, you have the right to access and get a copy of any data regarding your health information from Nourish Natural Health Clinic, LLC. In the exceptional cases in which we are permitted to withhold information from you, you may ask that the denial be reviewed. You have the right to amend your health information. We will amend the information, except if it a) is not information that we created, (unless the source of the information is no longer available to make the amendment), b) is not part of the health information that we keep c) is of a type that you would not be permitted to inspect and copy; d) is already accurate and complete.

Dr. May and all associates of Nourish Natural Health Clinic, LLC seek to maintain confidentiality regarding your health information. We are happy to discuss your concerns about these matters and consider further restricting use and disclosure of your health information.

Signature_____ Date Signed_____

Printed Name Relationship to Patient_____

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NOURISH NATURAL HEALTH CLINIC
FEE SCHEDULE

Payment is required at the time of service, unless previous arrangements have been made. We accept cash, checks, VISA, or Mastercard for payment.

New Adult Patient Office Visit	**$200**
(*approximately 1 ½ hours)*	
New Pediatric Patient Visit	**$150**
(approximately 1 hour)	
Routine Return Visit	**$60-90**
(approximately 60 min)	$90
(approximately 30 min)	$60
New Patient Acute Visit	**$120**
(*approximately 30 - 45 min)*	
Return Patient Acute Visit	**$60**
(*approximately 15 – 30 min)*	
Phone/Skype Consults	**$60-90**
(Same as Routine Return Visits)	

**Phone calls and email messages regarding questions about your current treatment plan, and taking less than 10 minutes of time, are not charged.*

**Any laboratory fees, imaging fees or natural supplement items that may be recommended are not included in the office visit fee.*

Insurance Reimbursement*:*

Currently, insurance companies and HMO's in Minnesota do not cover naturopathic services. Flex Spending programs may allow for naturopathic health care deductions. Check with your plan administrators. We recommend that everyone ask their insurance providers to allow coverage for natural healthcare expenses.
However, insurance billing for certain lab work is possible with some insurance companies.

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Cancellation Policy:

If you need to change or cancel your appointment, please give us at least 24 hours notice. Appointments that are either missed or cancelled with less than 24 hours notice (excluding emergencies) will be charged a $75 (New Patient Visits) or $40 (Return Visits) fee.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. May. I also understand that I will be billed for phone or Skype consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated, and lasting less than 10 minutes of time.

In addition, I understand that lab work may or may not be covered by my insurance plan and that I am responsible for payment of lab work ordered if my insurance company does not cover it. I also understand that I will be charged $35 for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: _____ Date: _____

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E-Mail Authorization and Consent Agreement Between Nourish Natural Health Clinic Clinician and Patient

I have been advised that:
E-mail is never, ever appropriate for urgent or emergency problems.
E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
All e-mail correspondence will become a part of my medical record at Nourish Natural Health Clinic, LLC. It is extremely important to include my name on each and every e-mail sent to Nourish Natural Health Clinic, LLC and/or Dr. May.
Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.
I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.
I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.
I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address: _____
E-mail address:_____
Signature:_____ Date:_____
Name:_____ DOB:_____
Printed Name of Clinician:_____
Signature of Clinician:_____